

Implementation and Evaluation of a Disaster-Related Injury Surveillance System Following an Outbreak of Severe Weather, Kentucky 2012

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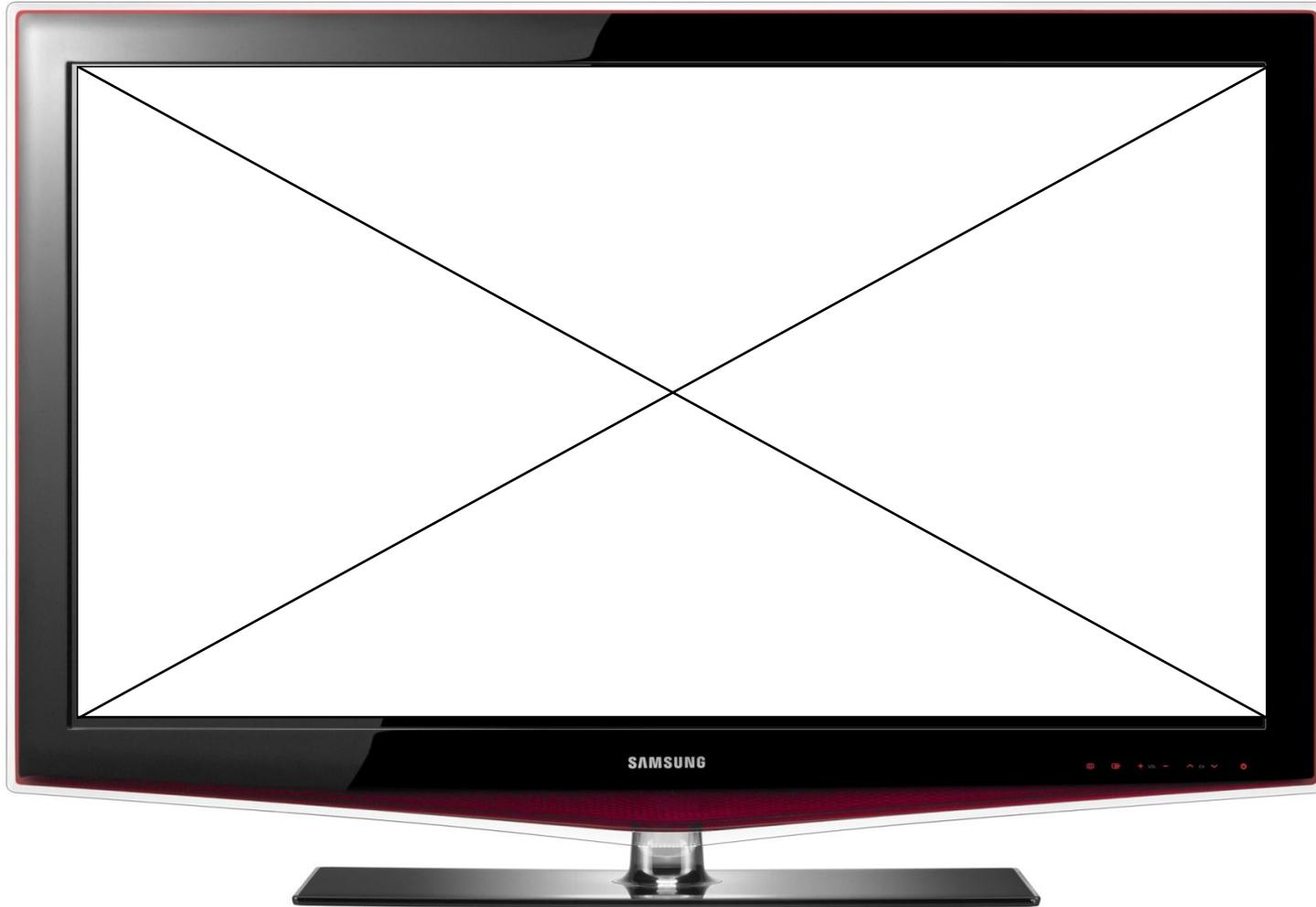
June 6, 2012



Background



West Liberty, KY



West Liberty, KY

CNN
iReport



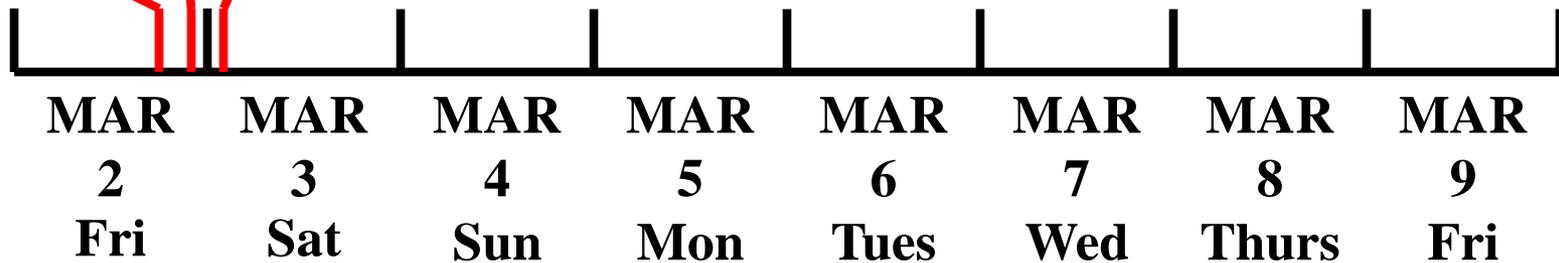
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Timeline of Response Events

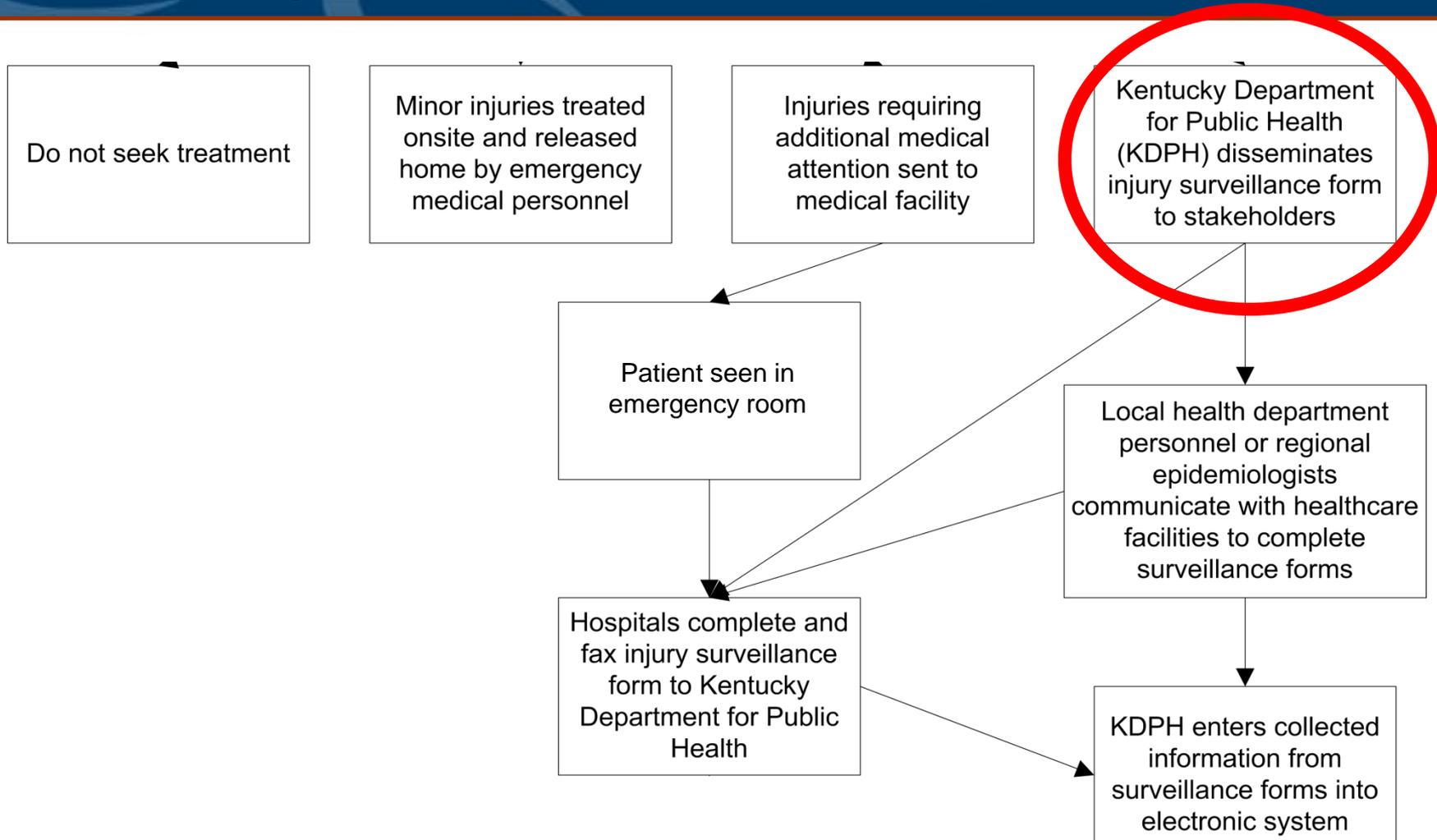


Healthcare-related Report Surveillance Form
 Complete the form for all adverse incidents related to a disaster. The information should be obtained from
 National OIG or other appropriate. Please complete one form per facility. Submit completed form daily
 to: The Department for Public Health via the Web Site at: [URL] for questions please call 502-562-5100

Part I - Facility Information	
1. Type of disaster: <input type="checkbox"/> Flood <input type="checkbox"/> Earthquake <input type="checkbox"/> Other (specify): _____	2. Facility type (select one): Please check one that best describes the facility: <input type="checkbox"/> Hospital <input type="checkbox"/> Other (specify): _____
3. Facility name: Name: _____ Address: _____ City: _____ State: _____	4. Contact person (individuals at facility): Name: _____ Phone number: _____ Email address: _____
Part II - Allegation Details	
5. Date of incident: Date: _____	6. Number transferred to this facility: _____
7. Facility name: Name: _____ Address: _____ City: _____ State: _____	8. Number transferred from this facility: _____
9. Date of incident: Date: _____	10. Number patients from out of state transported to facility: _____
Part III - Description of Incident	
11. Description of incident (in case of disaster, include number of patients in each category): Inpatient: _____ Outpatient: _____ Ambulatory: _____ Other: _____ Total: _____ Description of incident: _____ Date (time or clinical): _____ Extension (e.g., 10/1/01): _____ Extension code (e.g., 10/1/01): _____ Other (specify): _____ Unlabeled case of report: _____ Reporting agency (if not the facility that is submitting the report): _____ YES <input type="checkbox"/> NO <input type="checkbox"/> Signature of reporting official: _____ Date: _____ Title of reporting official: _____ Other (specify): _____	
12. Date of report completed: Date: _____	13. Name of person submitting: Name: _____

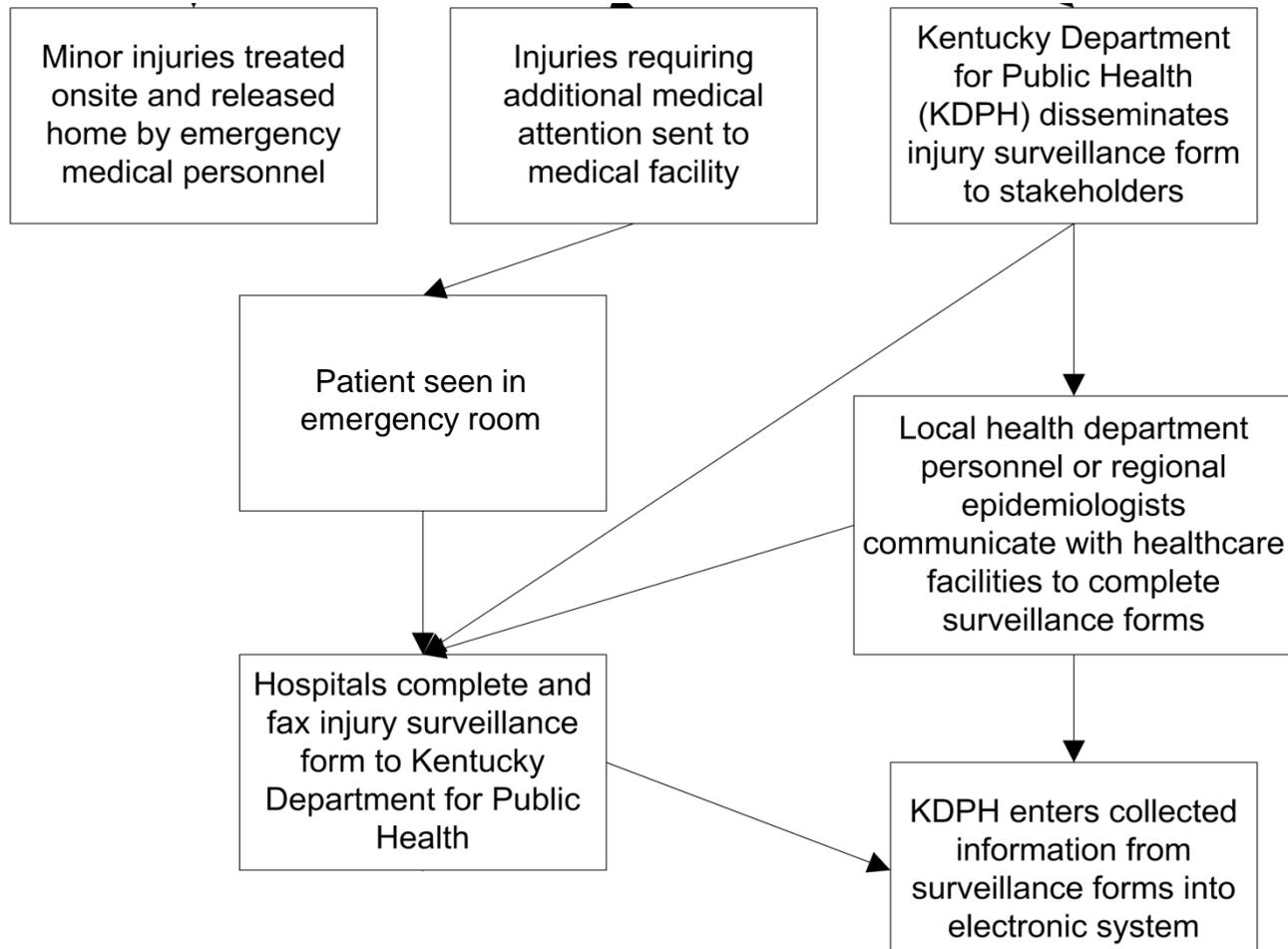


Injury Surveillance Operation

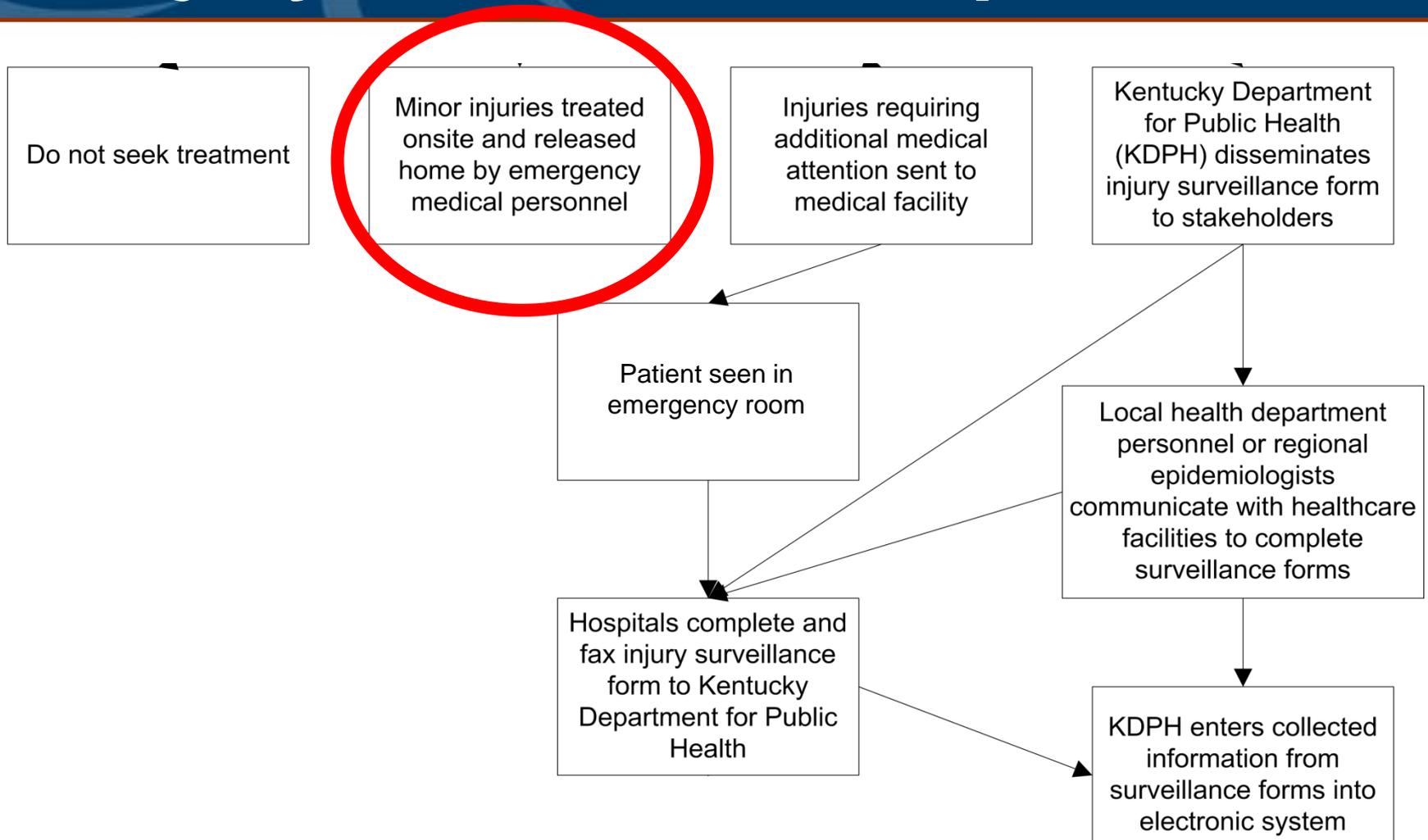


Injury Surveillance Operation

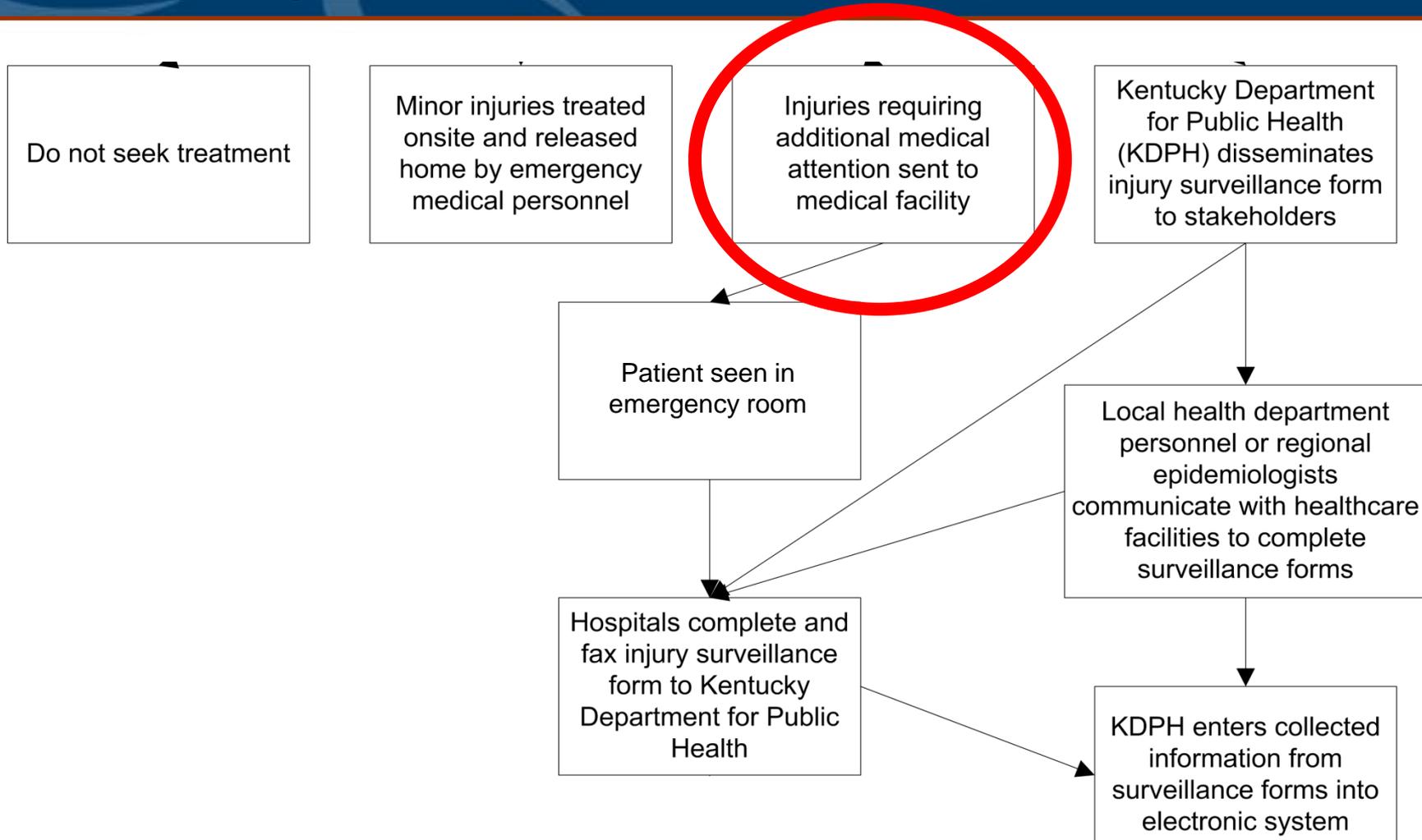
Do not seek treatment



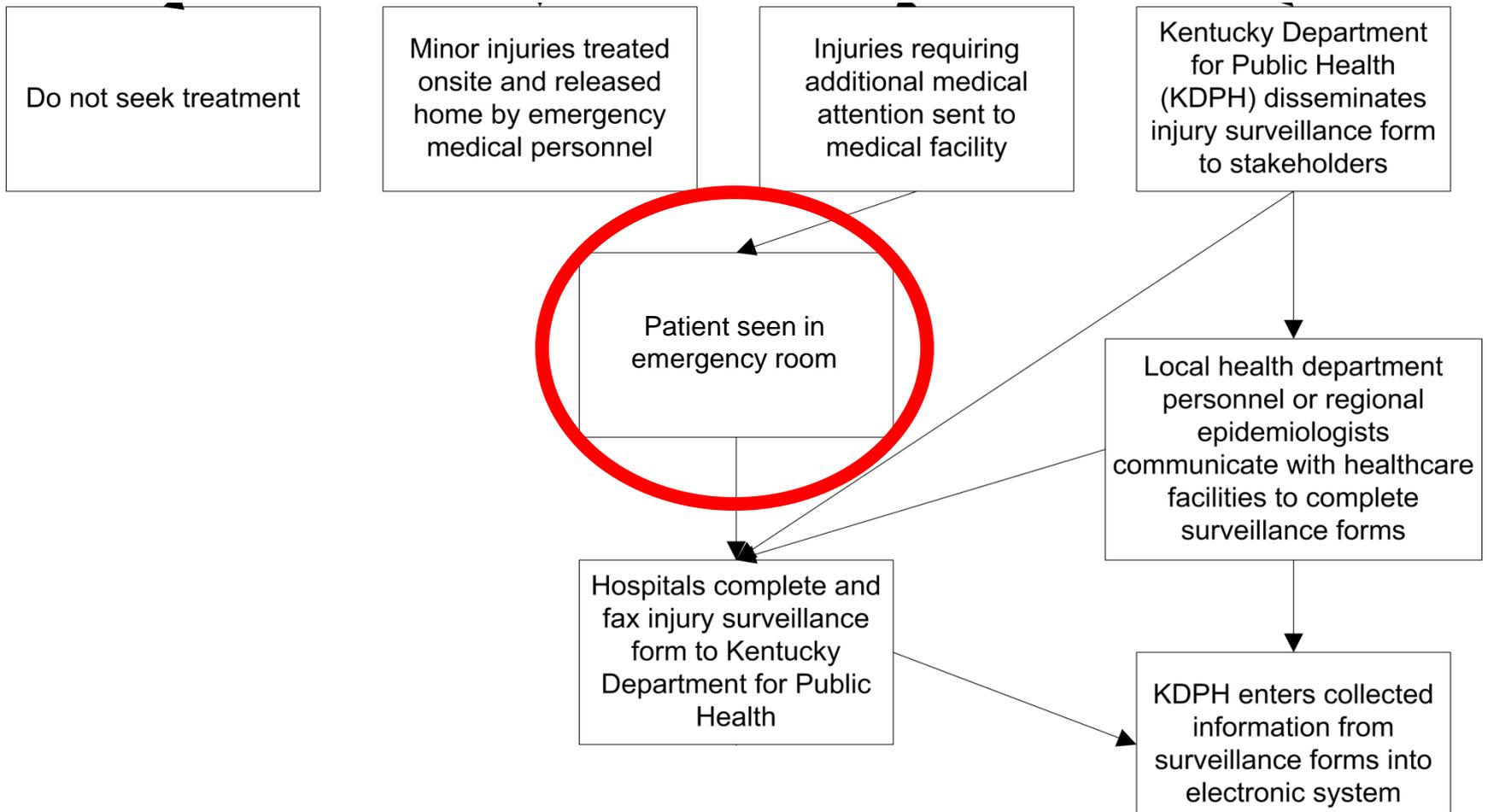
Injury Surveillance Operation



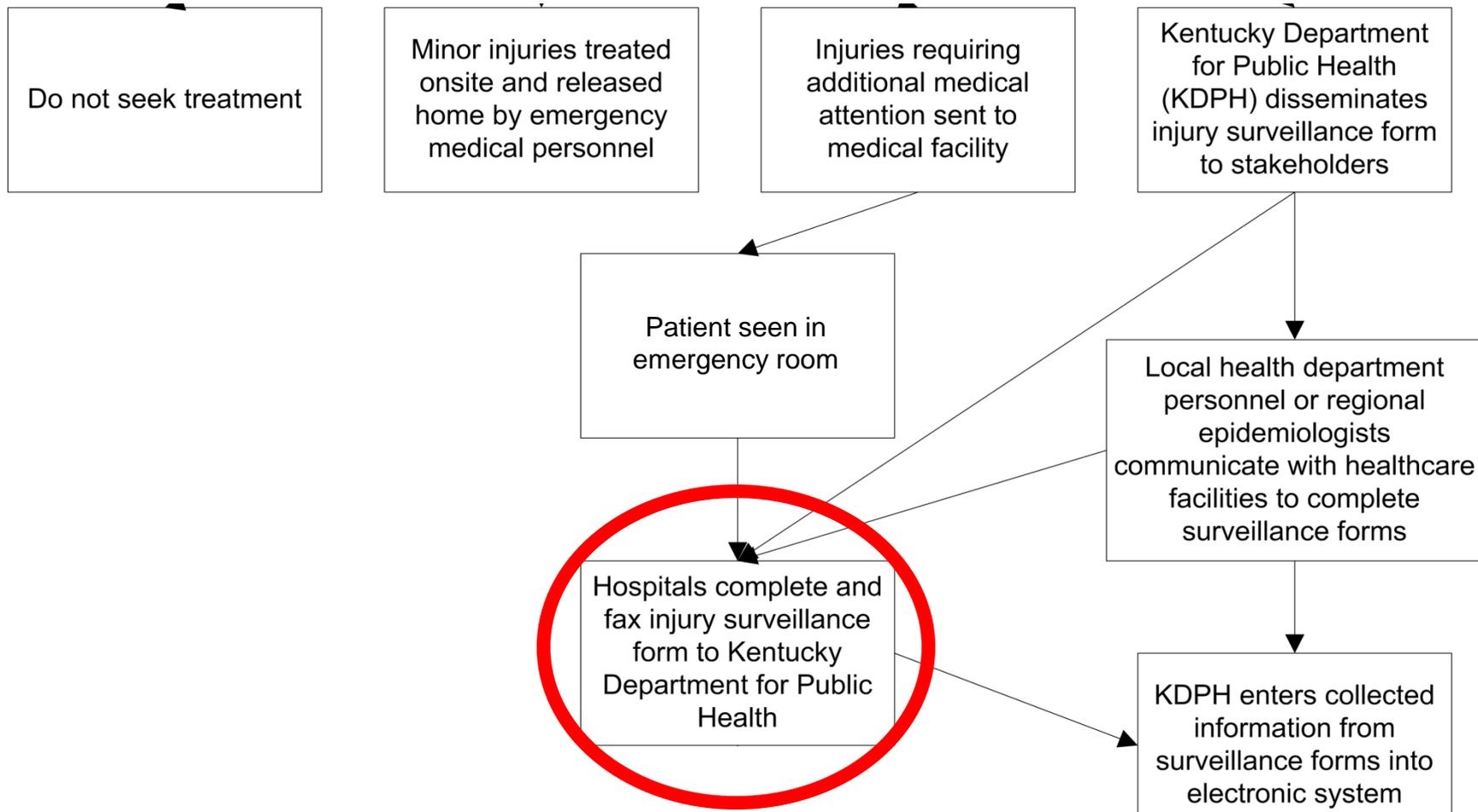
Injury Surveillance Operation



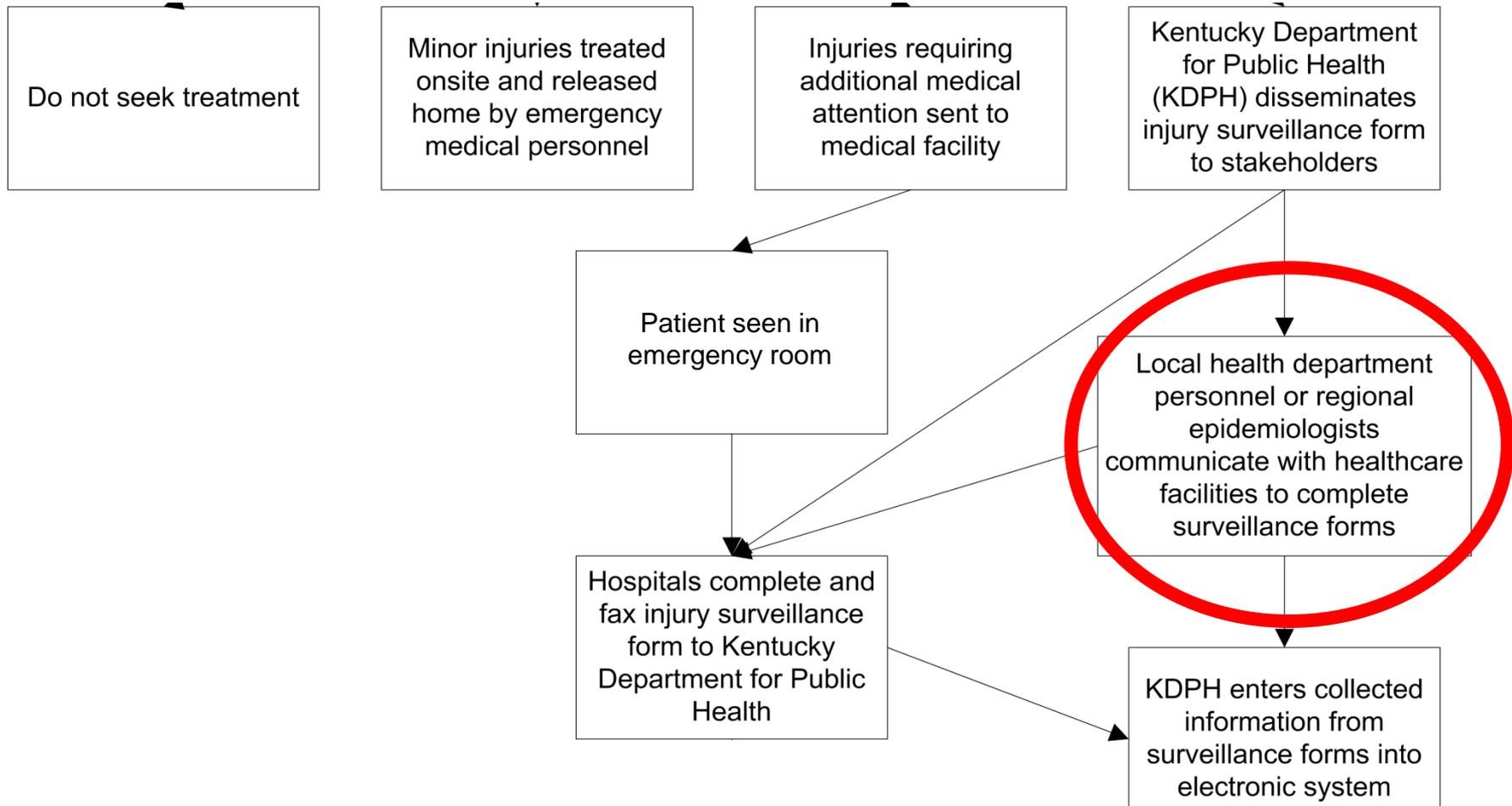
Injury Surveillance Operation



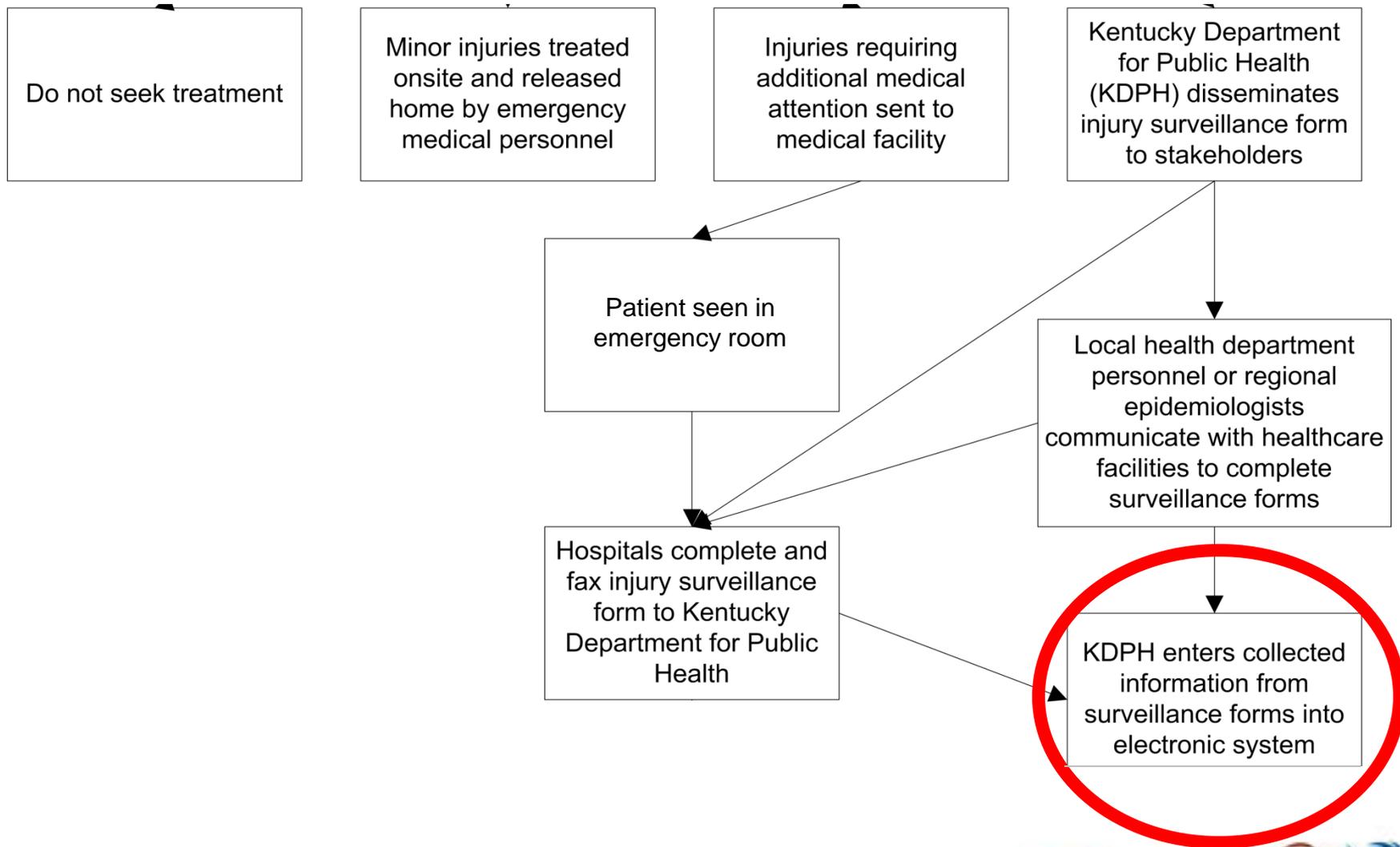
Injury Surveillance Operation



Injury Surveillance Operation



Injury Surveillance Operation



Surveillance Findings

Table 1. Submitted injury surveillance forms

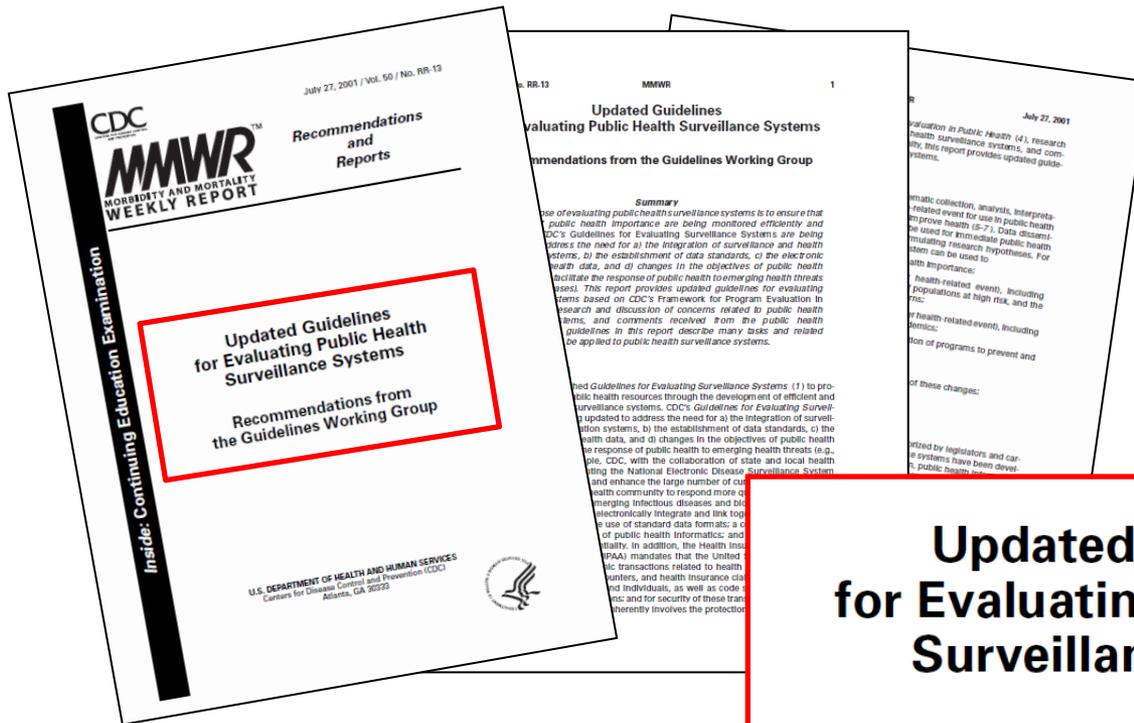
	3/2	3/3	3/4	3/5	3/6	3/7	3/8	Total
	F	Sa	Su	M	T	W	Th	
Type of Facility								
Long-Term Care Facilities	0	30	1	41	24	2	22	120 (59)
Hospitals	3	13	3	29	9	12	3	72 (35)
Shelters/Other Facilities	0	0	1	7	2	1	0	11 (5)
Total	3 (1)	43 (21)	5 (2)	77 (38)	35 (17)	15 (7)	25 (12)	203

Surveillance Findings

Table 2. Frequencies of storm-related injuries by severity

	3/2	3/3	3/4	3/5	3/6	3/7	3/8	Total
	F	Sa	Su	M	T	W	Th	
Injury Severity								
Minor	26	56	12	11	0	0	2	107
Serious	2	27	3	2	0	0	0	34
Life Threatening	1	10	1	0	0	0	0	12
Total	31	92	18	13	0	2	2	158

Evaluation Methods



Updated Guidelines for Evaluating Public Health Surveillance Systems

Recommendations from the Guidelines Working Group

Strengths

- Simple
- Flexible
- Stable
- Timely



Excellent
 Very good
 Good
 Average
 Poor

Areas for Improvement

- Data Quality
- Acceptability
- Representativeness



Conclusion

- Successful implementation
- Daily reports of observed injuries
 - Maintain situational awareness
 - Improved messages promoting responder and general public safety
- Address identified areas for improvements

Acknowledgements

- **Kentucky Department for Public Health**
 - Elizabeth Hoo, MPH, CLC
 - Margaret Riggs, PhD, MPH, MS
 - Doug Thoroughman, PhD, MS
- This work was supported in part by an appointment to the Applied Epidemiology Fellowship Program administered by the Council of State and Territorial Epidemiologists (CSTE) and funded by the Centers for Disease Control and Prevention (CDC) Cooperative Agreement Number 5U38HM000414



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